| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155219 | A. BUILDING _____ B. WING _____ | C 05/05/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REGENCY PLACE OF SOUTH BEND | 52654 NORTH IRONWOOD ROAD SOUTH BEND, IN 46635 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>This visit was for Investigation of Complaint IN00089833.<br><br>This visit was in conjunction with a Post Survey Revisit (PSR)) to the PSR completed on 3/24/11 to the Recertification and State Licensure Survey completed on 2/10/11.<br><br>Complaint IN00089833-Unsubstantiated due to lack of evidence.<br><br>Survey dates: May 04 and 05, 2011<br><br>Facility number: 000124<br>Provider number: 155219<br>Aim number: 100266730<br><br>Surveyors:<br>Antoinette Krakowski, RN, TC<br>Vicki Manuwal, RN<br>Bobbi Costigan, RN<br><br>Census bed type:<br>SNF/NF: 113<br>Total: 113<br><br>Census payor type:<br>Medicare: 20<br>Medicaid: 68<br>Other: 25<br>Total: 113<br><br>Sample: 3<br><br>Regency Place of South Bend was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| REGENCY PLACE OF SOUTH BEND | 52654 NORTH IRONWOOD ROAD SOUTH BEND, IN 46635 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br>Complaint Number IN00089833.<br><br>Quality review completed on May 6, 2011 by Bev Faulkner, RN | F 000 | | |